WORKERS UNITED CANADA
BENEFITS TRUST FUND

Enrolment / Change Form

Please print clearly and complete the entire form
Retain a photocopy for your files

PBAS
Suite 110 - 61 International Blvd
Toronto, Ontario M9W 6K4
Phone: 416-674-3350 1-800-461-4361

○ **New Hire** ○ **Add Dependents** ○ **Change of Beneficiary** ○ **Change of Address**
○ **Change in Marital Status** ○ **Change of Name (Former Name__________________)**

Employer Name__________________________________ **Date of Hire:** ________________

Employee Information: **Social Insurance Number**____________________________

Name: ____________________ / ____________________________ / ____________
LAST NAME FIRST NAME MIDDLE INITIAL

Address: ____ / ____________
Street Name and Number Apt./Suite No.

__________ / ____________________ / __________________ / ____________
City Province of Residence Postal Code Telephone

Date of Birth: ______ / ______ / ______
dd mm yyyy

Marital Status: Single ○ Married ○ Common-law ○
If your spouse is common law, please provide the effective date of union: ______ / ______ / ______
dd mm yyyy

Employee's Gender: Male ○ Female ○ Language of Preference: English ○ French ○

Employee's Regular Salary: $______________/year

2. Spousal Information

Name: ____________________ / ____________________________ / ____________
LAST NAME FIRST NAME MIDDLE INITIAL

Date of Birth: ______ / ______ / ______
dd mm yyyy

Spouse's Gender Female ○ Male ○

Spousal Health Coverage Does your spouse have health care coverage under his/her own plan?		**Spousal Dental Coverage** Does your spouse have dental care coverage under his/her own plan?	
Yes ○	Effective Date of Coverage	Yes ○	Effective Date of Coverage
No ○		No ○	

If yes, please provide details ______________________________ ____________
Name of Insurance Company Policy No.

NOTE: Failure to provide details of spousal coverage may affect your ongoing eligibility for benefit entitlement.

3. Dependent Children Information

Child's Name (Last, First)	Relation	Gender M/F	Date of Birth (dd/mm/yyyy)	Student/Disabled?
			____/____/_______	
			____/____/_______	
			____/____/_______	
			____/____/_______	
			____/____/_______	

4. Beneficiary Appointment

Name Of Beneficiary(ies) (Last, First, Middle Initial)	Relationship to Employee	Benefit %

I appoint the beneficiary, identified above, to receive any proceeds that become payable by result of my death. I reserve the right to change my beneficiary from time to time, subject to complying with the rules of the Benefit Plan, and the laws and regulations governing such matters. If my beneficiary predeceases me, and no other has been appointed, the proceeds, if any, will be payable to my estate.

5. Employee's Signature

I certify that the information provided here is true and complete, to the best of my knowledge. The information, provided through the completion of this Registration Form, will establish your identity as an Employee of the Employer.

BEFORE SIGNING THIS FORM, YOU SHOULD UNDERSTAND THE MEANINGS OF THE "EXPLANATION" AND THE "AUTHORIZATION". IF CLARIFICATION IS NEEDED, PLEASE CONTACT THE ADMINISTRATOR OF THE PLAN.

EXPLANATION --- Your participation in the Plan depends on the collection, storage and use of certain personal information about you, your dependents and beneficiary(ies). It comes from this form, and the claims/applications made for benefit entitlements. It is stored by the administrator of the Plan, and, it is used to: communicate with you; compute your benefits; satisfy the reporting requirements of the provincial and federal governments; pay taxes and comply with civil and criminal law; determine future operating costs; accommodate audits of the Plan; and, if applicable, transfer data to a new replacement plan. Personal information will be used for no other purpose without your express permission, and will be kept confidential and secure. Also, it is available for your review, by contacting the Administrator.

AUTHORIZATION --- I hereby authorize the Employer, and the Administrator of the Plan, to collect, record, use, disclose and, if applicable, destroy the personal information, noted above. This authorization will survive as long as my personal information is needed to fulfill my benefit entitlements, or until I revoke it in a manner that does not contravene the law. However, I realize that such revocation may impair my participation in the Plan. Furthermore, I certify that the information, given in this form, is true, correct, and complete, to the best of my knowledge and belief.

I authorize the use of my Social Insurance Number as an additional verification of my identity in the administration of my benefit entitlements and in the handling of any related tax matters. I understand that my Social Insurance Number will be kept in the strictest confidence and will only be used for the specified purposes.

If applying for benefits for my dependents, I am authorized to release information concerning my spouse and my children, for the purposes of determining their eligibility for benefits.

Employee's Signature	**Date Signed (dd/mm/yyyy)**